Ronitte Vilker, PhD
3657 Post Road, Suite 6
Warwick, Rhode Island 02886
(401) 921-3220

CHILD INFORMATION FORM

Patient Name: _____

Patient DOB: _____

Patient Gender: ___ female ___ male

Patient Address: _____

_____

Phone Number: _____ Email: _____

Parents Married: ___ yes ___ no

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INSURANCE INFORMATION

Insurance: _____ Member ID: _____

Authorization Number (when required by insurance): _____

Subscriber: _____

Relationship to Patient: _____

Insurance Phone Number for Providers on back of card: _____

Insurance Address: _____

Insurance Website: _____

Copay: _____

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OPTIONAL QUESTIONS

Only fill out if you would like me to have this information prior to our first session.

FAMILY COMPOSITION (parents' names, marital status, if not in one household-visitation, siblings, pets)

PRESENTING PROBLEM/HISTORY OF PROBLEM (When did problem start? Chronic or episodic? How does the problem present at home? At school? Where does the problem not occur?)

PAST HELP FOR THE PROBLEM (previous testing, counseling, medication, tutoring, etc.)

SIMILAR PROBLEMS IN THE FAMILY/FAMILY COMPOSITION (immediate family, extended family, learning disabilities, reading problems, mood or affect difficulties, etc.)

SCHOOL HISTORY (schools attended, past and present teacher concerns, problems/successes in school, past and present support services, current IEP or 504 Plan?)

SOCIAL HISTORY/INTERESTS AND HOBBIES

DEVELOPMENTAL HISTORY (neonatal; Jaundiced? Routine?)

EARLY DEVELOPMENTAL MILESTONES (walking, talking, fine motor, toilet training, etc.)

LANGUAGE DEVELOPMENT (problems understanding or remembering language, trouble pronouncing words with many syllables, trouble finding words, trouble following directions, problems expressing needs, ideas, etc.)

SENSORY SENSITIVITIES (i.e., picky about foods, clothing, tags, sounds, touch)

MOTOR DEVELOPMENT (running, balance, coordination, use of playground equipment, coloring, use of scissors, preferred types of toys, play activities that are avoided)

MEDICAL HISTORY (history of ear infection, allergies, frequent congestion, hospitalization/accidents/surgeries, high fevers/convulsions/head injuries, chronic conditions/residual problems/physical limitations, medications/side effects from medications, sleep patterns/eating patterns, usual sensory sensitivities (touch, sounds, temperature, clothing, etc.), primary care physician)

SUBSTANCE USE (alcohol, drugs) if relevant

TRAUMA HISTORY (Has anything of a traumatic nature happened in the child's or adolescent's lifetime? Accidents? Abuse? Excessive teasing?)

ADHD SCREENING QUESTIONS (ability to sustain mental effort during activities other than TV or the computer, organization and planning skills, forgetfulness/losing materials, homework completion, number of reminders needed to complete a task, overall activity level, ability to complete one task before starting another task, distractibility levels in different settings)

ANXIETY/DEPRESSION SCREENING QUESTIONS (worries, fears, or concerns that affect willingness to complete normal or routine activities, recent changes in interests, appetite, sleep patterns, levels of irritability)